90-72

No. ———

IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

JUDY C. BROWN and LEWIS F. BROWN, Individually And As Next Friends of REIDER P. M. BROWN, A Minor and REISE G. L. BROWN, A Minor, Deceased,
Petitioners

v.

ANDY GRANATELLI, As Trustee of TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN; THE TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN, and NORTH AMERICAN LIFE AND CASUALTY COMPANY,
Respondents

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

IRA D. WATROUS*
WATROUS & ASSOCIATES
Houston, Texas 77025
(713) 666-3719
Counsel for Petitioners
Judy C. Brown,
Lewis F. Brown,
Reider P.M. Brown, a minor,
Reise G. L. Brown, a minor

*Counsel of Record

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

THE QUESTIONS PRESENTED FOR REVIEW

1. Can a Benefit Plan spend plan funds to insure itself against catastrophic loss without including its plan members in that coverage?

2. If a Benefit Plan can spend plan funds to insure itself, can it (Tuneup Masters, Inc.'s plan) purchase an insurance policy against catastrophic loss from an insurance company (NALAC) and then take the position that it, the Plan, is "self insured"?

3. If a benefit plan can "insure itself" and maintain the position that it is self insured but its members are not insured, even though its members are the ones suffering the catastrophic losses in fact and even though it is the members premium dollars that provide coverage for the dependents, can the carrier writing the coverage ignore the mandated benefits laws of the several states (all 50 in this instance) under the theory that it, the insurance company, is not insuring the individual members of the plan but rather the plan itself against the catastrophic losses of its individual members?

4. Can enforcement statutes, employed in conjunction with other statutes used specifically to regulate the business of insurance, be pre-empted by ERISA under the theory that "enforcement statutes do not regulate insurance" and thus are pre-empted?

5. With reference to the *Pilot Life* decision by the United States Supreme Court, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), which decision holds, among other things, that laws directed specifically to the insurance industry are exempted from ERISA but that state laws which are "general" in nature are preempted. Can the Supreme Court, after due reflection continue upholding *Pilot Life* when its decision was predicated, among other things, on the proposition that by referring to the language in the statutes used by Congress and specifically

directed towards the insurance industry, Congress must have intended to exclude any statutes from exemption if they were parallel to similar "general statutes" even when, as in the *Pilot Life* instance, the subject general statutes were designed to discourage unconscionable conduct.

To maintain *Pilot Life*, in its present position under the above reasoning the United States Supreme Court would necessarily be adopting the position that since the several states (across the board) were against unconscionable conduct, as a general proposition and as used in their "general statutes" then Congress must have been casting a vote for unconscionable conduct with reference to any statute directed to the insurance industry when that statute happened to parallel any general statute of any of the several states.

The question then is "if one considers the reasoning in Pilot Life as it relates to "Congressional Intent" and then reviews the language in the McCarran-Ferguson Act can the inconsistency be reconciled?

A LIST OF ALL PARTIES TO THE PROCEEDING IN THE COURT WHOSE JUDGMENT IS SOUGHT TO BE REVERSED AS REQUIRED BY SUPREME COURT RULE 24.1(b)

Parties to the proceeding are as follows:

1. Andy Granatelli, as Trustee of Tuneup Masters, Inc. Employee Benefit Plan
   Los Angeles, California

2. The Tuneup Masters, Inc. Employee Benefit Plan
   Los Angeles, California

3. North American Life and Casualty Company
   Milwaukee, Wisconsin

4. Judy C. Brown, Plaintiff-Petitioner
   Houston, Texas

5. Lewis F. Brown, Plaintiff-Petitioner
   Houston, Texas

6. Reider P. M. Brown, a minor, by and through his next friends, his parents Judy C. Brown, and Lewis F. Brown, Plaintiffs-Petitioners

7. The estate of Reise G. L. Brown, a minor, deceased, Houston, Texas

8. First Fund Insurance Administrators, Inc., a non-party, currently has no direct financial interest in this litigation but is factually involved in this dispute.
   Los Angeles, California

9. Mr. Gary Lawson
   Goodwin, Carlton & Maxwell
   3300 First Republic Bank Plaza
   901 Main Street
   Dallas, Texas 75202-3714
   Attorney for Andy Granatelli, as Trustee and Tuneup Masters, Inc. Employee Benefit Plan

10. Mr. James J. McConn, Jr.
Hays, McConn, Price and Pickering
400 Citicorp Center
1200 Smith Street
Houston, Texas 77002
Attorney for North American Life and Casualty Insurance Company

11. Mr. Terry Price
Constangy, Brooks, & Smith
230 Peach Tree Street, N.W. #2400
Atlanta, Georgia 30303-1557
Attorney for Andy Granatelli, as Trustee and Tuneup Masters, Inc. Employee Benefit Plan

12. Mr. Ira D. Watrous
Watrous & Associates
3729 Murworth
Houston, Texas 77025
Attorney for Plaintiff-Petitioners, Judy C. Brown, Lewis F. Brown, Reider P. M. Brown, a minor, and Reise G. L. Brown, a minor, deceased.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

No. ———

JUDY C. BROWN and LEWIS F. BROWN, Individually And As Next Friends of REIDER P. M. BROWN, A Minor and REISE G. L. BROWN, A Minor, Deceased,

Petitioners

v.

ANDY GRANATELLI, As Trustee of TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN; THE TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN, and NORTH AMERICAN LIFE AND CASUALTY COMPANY,

Respondents

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

The Petitioners, Judy C. Brown and Lewis F. Brown, in their respective capacities, respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Fifth Circuit entered in the above referenced matter on April 11, 1990 as reproduced in the Appendix hereto (App. A at page 1a, which said judgment affirmed a Final Judgment Rendered by the United States District Court For The Southern District of Texas, Houston Division, Honorable Judge Normal L. Black presiding, said judgment entered

in the above referenced matter on January 24, 1989 as reproduced in the Appendix hereto (App. C at page 23a and which judgment was rendered in conjunction with a Memorandum and Order from that same Court and on that same day as reproduced in the Appendix hereto (App. B at page 16a).

OPINIONS BELOW

The Opinion of the United States Court of Appeals for the Fifth Circuit reported at —— F.2d —— (5th Cir. 1990) is reproduced and attached in full as Appendix A. The Memorandum and Order of the United States District Court for the Southern District of Texas, Houston, Division and the Final Judgment of that same Court, which are the subject of the affirmance by the Fifth Circuit are reproduced and attached in full as Appendences B and C respectively.

JURISDICTION

The judgment of the Court of Appeals was entered on April 11, 1990. See App., infra, at 1a. This petition is, accordingly, filed within the time allowed by law. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATEMENT OF THE CASE

On September 22, 1987, Petitioners filed suit in the 133rd Judicial District Court of Harris County, Texas against Andy Granatelli, As Trustee of Tuneup Masters, Inc. Employee Benefit Plan and the Tuneup Masters, Inc. Employee Benefit Plan. Defendants subsequently removed the case, pursuant to 28 U.S.C. § 1331. Thereafter North American Life and Casualty Company was added as a party defendant.

With permission of the trial judge the parties, having agreed that there was no dispute as to the material facts,

filed cross-motions for summary judgment. After due consideration the trial judge denied the motion for summary judgment of the Plaintiff-Petitioners and granted the motions for summary judgment of the defendants Andy Granatelli, as Trustee of the Tuneup Masters, Inc. Employee Benefit Plan, the Tuneup Masters, Inc. Employee Benefit Plan and North American Life and Casualty Company.

On appeal the Fifth Circuit, after hearing oral arguments, on April 11, 1990 rendered its judgment. (See App. A) affirming the judgment of the trial court.

Factually the case developed as follows: Judy C. Brown gave birth to her first child, a son, Reider P. M. Brown in January of 1986; Reider was severely premature and had serious, permanent physical problems as a result of that prematurity. In November of 1986 the Browns had a second son, Riese G. L. Brown. Reise was also premature and had serious congenital defects. After 5 months in the hospital Reise died. . . . The Browns made a claim for benefits under their group plan as described in a brochure published by the Benefit Plan. Their claim was denied. When the claim was denied the Browns sought relief by filing suit in state court, urging, inter alia, that they were entitled to state mandated benefits under Tex. Ins. Code Ann. art. 3.70-2(E).

The Browns contend, among other things, that the state of Texas has mandated benefits to cover new-born children and that ERISA does not pre-empt the states right to enforce compliance. The Browns further contend that a Plan is prohibited by express provision in ERISA from purchasing an insurance policy to cover the Plan at the expense of the Plan members. The Browns also contend that an insurance policy is an insurance policy and that labeling it "stop-loss" to mask a standard deductible (albeit a large deductible in this case) does not alter the fact that it is still insurance.

REASONS FOR GRANTING THE WRIT

From the time of the adoption of the U.S. Constitution, insurance companies have been subject to state regulation and taxing; a situation fully recognized by the U.S. Supreme Court and as pointed out in *Paul v. Virginia*, 75 U.S. 357 (1869). In 1944 the *S.E. Underwriters* case *United States v. South-Eastern Underwriters Ass'n et al.*, 322 U.S. 533 (1944), created need for the McCarran-Ferguson Act. The Congress clearly demonstrated its intent to keep the insurance industry subject to regulation and taxation by the several states by, within three weeks, passing a bill restoring that power to the states. That particular bill did not clear the Senate but in 1945 Congress passed the McCarran-Ferguson Act, 15 U.S.C. Sec. 1011. In that Act Congress declared that it was in the public interest that the several states continue to tax and regulate the business of insurance. . . . In 1946 South Carolina imposed a tax on Prudential Insurance and that tax was upheld by the U.S. Supreme Court in *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408 (1946). . . . In that case the Court noted that "Obviously Congress purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance . . . and all who engage in it shall be subject to the laws of the several states in these respects." . . . In 1974 ERISA was enacted . . . but did not and does not specifically relate to the business of insurance and therefore does not preempt the McCarran-Ferguson Act. . . . Sec. 1103(c) of ERISA directs that assets of plans . . . "shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan." . . . In 1978 in *Group Life and Health Ins. v. Royal Drug Co.*, 440 U.S. 205 (1979), the Court set up the three-prong test, quoted from *National Securities, Securities and Exchange Commission v. Nat'l Securities, Inc.*, 393 U.S. 453 (1969), and included "enforcement." . . . In

1985 in *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724 (1985), the U.S. Supreme Court said ". . . plans may self-insure or they may purchase insurance for their participants . . . insured plans are directly effected by state law." Couple this with the McCarran-Ferguson Act, ERISA Secs. 1002(1), 1103(c) and 1144(b)(2)(A) and you reach the inescapable conclusion that insured plans are subject to state law. The Tuneup Masters Plan is an insured plan. . . . In 1986 the Sixth Circuit in *Michigan United Food and Commercial Workers Union v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), said "The Stop-Loss nature of the plan does not alter our conclusion." (btm p. 312). . . . In 1986 the Ninth Circuit in *Moore v. Provident Life and Accident Ins. Co.*, 786 F.2d 922 (9th Cir. 1986), held opposite to the holding of the 6th Circuit in the *Bearwaldt* case. Petitioners do not argue that plans cannot purchase insurance, be it labeled "stop-loss", "deductible" or whatever. But a plan cannot legally use plan funds to purchase stop-loss coverage to protect itself against catastrophic loss for the simple reason that any plan can eliminate catastrophic risk exposure by simply writing it out of the plan, because ERISA does not control the substantive content of any plan. This allows any plan to "write out" any risk that it does not wish to assume, e.g. "Under no circumstance will this plan be liable for health care expenses in excess of $—— Dollars" (the plan can fill in any desired amount) . . . "Under no circumstance will this plan be liable for health care expenses in excess of the limits of the insurance coverage provided for the members through the plan." Sec. 1103(c) of ERISA says that plan funds can only be used for the benefit of members, dependents and reasonable administrative expenses . . . the funds cannot, repeat cannot, be used to purchase stop-loss coverage to protect against catastrophic loss when the exposure can be eliminated by writing out the risk at no expense to the plan or its members . . . . Contrary to Congressional Intent the *Moore* case allows insurance companies to operate in

an unregulated market in spite of the fact that they are insurance companies, engaged in the business of insurance. Sec. 1002(1) of ERISA doesn't allow it, Sec. 1103 (c) prohibits it and Sec. 1144(b)(2)(A) "saves State Regulation." . . . Consequently the plan is subject to indirect regulation under *Metropolitan*. . . . Self-Insure, as commonly used, means to insure one's self, *i.e.*, for a plan to hold sufficient reserves to cover reasonable contingencies. By purchasing insurance from NALAC the plan insured itself but it did not become self insured. . . . The Browns with one baby dead and over $700,000.00 in unpaid medical bills are living proof of the importance of enforcing mandated benefits laws and an outstanding example of why the insurance industry came up with "stop-loss" coverage as a ploy to escape from state mandated benefits. . . . With a finite number of premium dollars available the insurance industry can only maximize its profits by eliminating high risk coverage. The Ninth Circuit is assisting the insurance industry in that direction with its holding in the *Moore* case. . . . The *Moore* case when coupled with the *Juckett* case, *Juckett v. Beecham Home Improvement Products, Inc.*, 684 F.2d Supp. 448 (N.D. Tex. 1988), compounds the problem by eliminating the ability of the several states to enforce their various mandated benefits under the theory that enforcement statutes are not "regulatory" and are therefore preempted by ERISA. Holding that even if you can apply mandated benefits you can't enforce them. The need for mandated benefits to protect the public was established after many years of overreaching by the insurance industry. Now the Federal Courts through *Pilot Life*, *Moore*, *Juckett* and other similar holdings are destroying the ability of the several states to protect their citizens (the citizens of the United States) from the insatiable greed of the insurance industry at the expense of Lewis and Judy Brown and all others similarly situated.

PROPOSED ANSWERS TO QUESTIONS PRESENTED FOR REVIEW

1. A Benefit Plan cannot spend funds to prevent catastrophic loss unless the coverage is extended to and benefits the individual members.

2. A Plan cannot take the position that it is self-insured by virtue of having purchased so called stop-loss insurance and in so doing deny insurance coverage to its members individually.

3. An insurance company cannot write stop-loss coverage for a benefit plan unless it complies with the mandated benefit laws of the state in which the plan is insured.

4. Enforcement statutes that pertain to the business of insurance are an integral part of the regulation and taxation mechanism that the several states employ and cannot be preempted by ERISA under the theory that they, individually, are not regulatory per se.

5. The U.S. Supreme Court decision in the *Pilot Life* case should be reviewed in light of the expressed intent of Congress in the McCarran-Ferguson Act and modified to comport with that expressed intent.

CONCLUSION

Judge Brown, in his dissenting opinion in Appendix A points out that the majority opinion (App. A) creates a system whereby insurance companies can avoid the operation of the Texas Insurance Code. The Brown family, in this instance, is living proof of what happens to the workers when an insurance company is allowed to operate in a Court Created unregulated market. Allowing the plan members access to the state mandated benefits otherwise available to non-member policy holders will protect them from the profit at any cost operation that has thus far victimized the Browns and will unquestionably victimize countless others unless this Court undoes the harm and havoc created by the holding in *Pilot Life* and the Ninth Circuit holding in the *Moore* case.

Accordingly a writ of certiorari should issue to review the judgment.

Respectfully submitted,

IRA D. WATROUS*
WATROUS & ASSOCIATES
Houston, Texas 77025
(713) 666-3719
Counsel for Petitioners
Judy C. Brown,
Lewis F. Brown,
Reider P.M. Brown, a minor,
Reise G. L. Brown, a minor

*Counsel of Record

APPENDICES

APPENDIX A

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

No. 89-2171

JUDY C. BROWN and LEWIS F. BROWN, Individually and a/n/f of REIDER P.M. BROWN, A Minor, and REISE G.L. BROWN, A Minor, Deceased,

Plaintiffs-Appellants,

v.

ANDY GRANATELLI, As Trustee of TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN; THE TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN, and NORTH AMERICAN LIFE and CASUALTY COMPANY,

Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of Texas

April 11, 1990

Before BROWN, REAVLEY, and HIGGINBOTHAM, Circuit Judges.

PATRICK E. HIGGINBOTHAM, Circuit Judge:

The Browns appeal the district court's grant of summary judgment in favor of Tuneup Masters Employee Benefit Plan, Andy Granatelli, the Plan's trustee, and

North American Life and Casualty Company which upheld the denial of benefits under the Plan for two of the Browns' children who were born premature with congenital defects. The district court found that the Employee Retirement Income Security Act of 1974 preempted the application of Tex.Ins.Code Ann. art. 3.70-2(E) to the Plan, Granatelli, or NALAC. Article 3.70-2(E) requires individual and group health insurance policies to provide coverage for newborn babies with congenital defects. The district court also found that the Plan was not structurally defective. We affirm the district court's grant of summary judgment in favor of the Plan, Granatelli, and NALAC.

I

The Plan is a group medical plan providing certain health care benefits for employees of Tuneup Masters and their eligible dependents. The Plan has been maintained by Tuneup Masters since 1980 as an employee welfare benefit plan within the meaning of ERISA. First Fund Insurance Administrators administers the plan and is solely responsible for processing and paying the claims of Tuneup Masters' employees and their dependents. Tuneup Masters funds the Plan for all covered employees. The employees pays for the cost of his dependents if dependent coverage is elected.

Mr. Granatelli, as the owner of Tuneup Masters, purchased excess or "stop-loss" insurance from NALAC. Under the policy NALAC reimburses the Plan for claims the Plan pays which exceed $30,000 for any covered individual during the policy year. From the end of 1983 through 1988 only four individuals out of an average of over 800 individuals covered by the Plan yearly submitted claims in excess of the $30,000 stop-loss coverage attachment point. NALAC has no authority to approve claims or otherwise to manage the plan and no authority to approve changes in the plan itself.

In 1985 the Plan was amended in response to the large expense of premature birth. As amended, the Plan excludes coverage for all newborn babies until the 31st day after birth. The Plan also excludes coverage for any baby which on the 31st day is disabled, hospitalized, or sick.

The Browns' first child was born in January 1986. The child was premature with related physical problems requiring extensive medical care and treatment. The Browns' second child was born in November 1986, also premature and with birth defects. He remained in the hospital until his death five monthe later. The Plan refused to pay for the children's treatment because the expenses were incurred during the 30-day waiting period and because the children were not eligible for coverage because of their preexisting disabilities and hospital confinement.

The Browns then filed suit in state court against the Plan and Granatelli. The Plan and Granatelli removed the case to federal district court based upon the presence of a federal question and then joined NALAC as a third party defendant.

The parties stipulated that there were no genuine issues of material fact and moved for summary judgment. The Browns sought the denied benefits and other damages based upon two theories relevant to this appeal; that Tex.Ins.Code Ann. art. 3.70-2(E) required the Plan and NALAC's policy to cover newborns and that the Plan was structurally defective because it did not. The district court denied the Browns' motion for summary judgment and granted defendants' motion, holding that ERISA preempted Article 3.70-2(E) and that the Plan was not structurally defective.

II

The Browns admit that if Article 3.70-2(E) by its letter applied directly to employee benefit plans, its ap-

plication would be preempted by ERISA. In *Metropolitan Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), the Court held that mandated-benefit laws directly applicable to employee benefit plans are preempted by ERISA. *Id.* at 735 n. 14, 747, 105 S.Ct. at 2387 n. 14, 2393. However, according to the Court, plans which purchase insurance can be indirectly regulated by mandated-benefit laws because ERISA does not prevent those laws from being applied to the insurance policies which plans purchase. *Id.* at 747 & n. 25, 105 S.Ct. at 2393 & n. 25. Although the facts of *Metropolitan* are distinguishable from the facts of this case—the insurance policies at issue in *Metropolitan* were group insurance policies purchased by plans for the plan participants and not stop-loss policies—the Browns argue that under *Metropolitan* Article 3.70-2(E) can be applied to the Plan indirectly through the stop-loss policy it purchased from NALAC. Article 3.70-2(E) cannot require the Plan to provide mandated coverage, and because we conclude that Article 3.70-2(E) does not apply to stop-loss insurance purchased by an employee benefit plan to insure that plan against catastrophic loss, we do not reach the ERISA preemption issues as to stop-loss insurance coverage.

III

Article 3.70-2(E) requires that

> [n]o individual policy or group policy of accident or sickness insurance, . . . which provides for accident and sickness coverage of additional newborn children or maternity benefits, may be issued . . . if it contains any provision excluding or limiting the initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child.

Tex.Ins.Code Ann. art. 3.79-2(E) (Vernon 1981). "Accident and Sickness insurance" is defined broadly as "any policy or contract providing insurance against loss from

sickness or from bodily injury or death by accident or both." Tex.Ins.Code Ann. art. 3.70-1(B)(3) (Vernon 1981).

NALAC argues that an insurance policy purchased by an employee benefit plan to protect that plan from catastrophic loss is not accident and sickness insurance even though it indirectly covers accident and sickness losses. NALAC argues that Article 3.70-2(E) only applies to insurance purchased for sick or injured individuals. With one important qualification, we agree.

Subchapter G of the Texas Insurance Code contains the provisions dealing with accident and sickness insurance. Few if any can appropriately be applied to an insurance policy that reimburses an employee benefit plan for catastrophic loss and does not pay sick or injured persons. *See* Tex.Ins.Code Ann. 3.70-1 to -3 (Vernon 1981 & Supp.1989). The focus of Subchapter G is on protecting sick or injured individuals; Subchapter G has nothing to say about protecting employee benefit plans from catastrophic loss. The statement of purpose in Subchapter G is illustrative. It states:

> The purpose of this Act shall be to provide for reasonable standardization, readability, and simplification of terms and coverages contained in individual accident and sickness insurance policies; to facilitate public understanding of coverages; to eliminate provisions contained in individual accident and sickness insurance policies which may be unjust, unfair, misleading, or unreasonably confusing in connection with the purchase of such coverages or with settlement of claims; and to provide for full and fair disclosure in the sale of accident and sickness coverages.

Tex.Ins.Code Ann. art. 3.70-1 (Vernon 1981). Article 3.70-2(E) fits this statutory scheme, and we decline to apply it to stop-loss insurance purchased by an employee benefit plan to protect itself against catastrophic loss.

That is, we are persuaded that under Texas law stop-loss insurance is not accident and sickness insurance. *Accord Cuttle v. Federal Employees Metal Trades Council*, 623 F.Supp. 1154, 1157 (D.Me.1985) (holding that a stop-loss insurance policy is not group health insurance under Maine law); *cf. United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir.1986) (holding that because stop-loss insurance is not health insurance for plan participants, a plan which purchases such insurance is not an insured plan subject to state regulation under *Metropolitan*).

Article 3.70-2(E) prohibits health and accident insurance policy provisions that exclude or limit the coverage of newborns with congenital defects. The policy issued by NALAC contains no limiting provisions; NALAC reimburses the Plan for all the losses it incurs up to $1,000,000.00 per person in excess of the $30,000.00 per person stop-loss attachment point. The Plan, however, does not incur any losses because of newborns with congenital defects, and the state is preempted by ERISA from requiring the Plan to include those losses. Section 514(a) of ERISA preempts all state laws which "relate to" employee benefit plans. 29 U.S.C. § 1144(a). At the same time, the preemptive effect of § 514(a) is limited by § 514(b)(2)(A), the "insurance savings clause," which states that, with one exception, nothing in ERISA "shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). The "deemer clause," § 514(b)(2)(B), however, provides that no employee benefit plan "shall be deemed to be an insurance company . . . or to be engaged in the business of insurance . . . for purposes of any law of any state purporting to regulate insurance companies." 29 U.S.C. § 1144(b)(2)(B). Because of the deemer clause the Plan's payments to beneficiaries cannot be considered insurance payments. Under *Metropolitan* the mandated benefit law

cannot apply to the Plan itself, but only to health and accident insurance it purchases.

By adopting words of exclusion to express its purpose the Texas legislature plainly intended that coverage be mandated only when the primary coverage of a policy is for health and accident coverage. Here the primary coverage is for the Plan's catastrophic losses. We find additional support for our decision in the language of Article 3.70-2(E) limiting the statute's application to "individual" or "group" accident and sickness insurance policies. "Individual" policies are purchased by an individual for himself and his family. *See* Tex.Ins.Code 3.70-2(A)(3) (Vernon 1981). "Group" policies are purchased by an employer or other qualified organization for a group or individuals and their families. *See* Tex.Ins. Code 3.51-6, sec. 1(a) (Vernon Supp.1989). Read literally, the stop-loss policy purchased by the Plan is not an "individual" or "group" policy since it does not benefit individuals, but the Plan itself.

At the same time, we are wary lest an overly literal reading of the statute frustrate an otherwise manifest legislative purpose. We do not suggest that Article 3.70-2(E) can be avoided by naming an employee benefit plan as the insured on a policy which in reality insures the plan participants. If, for example, a plan paid only the first $500 of a beneficiaries' health claim, leaving all else to the insurer, labeling its coverage stop-loss or catastropsic coverage would not mask the reality that it is close to a simple purchase of group accident and sickness coverage. We look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan participants, recognizing that as insurance is less for catastrophic loss, it is increasingly like accident and sickness insurance for plan participants. In this case the fact that the Plan has only had to call on NALAC to reim-

burse it for its payments to four individuals in five years supports the Plan's assertion that the insurance is for itself and not for the plan participants. In short, if the Plan were merely a conduit for claims from participants to NALAC we would not reach the same conclusion.

IV

In sum, we hold that Article 3.70-2(E) does not apply to an insurance policy which insures a plan against catastrophic losses. Because all of the Browns' grounds for reversal derive from the failure of the Plan, Granatelli, and NALAC to comply with Article 3.70-2(E), the district court's grant of summary judgment in favor of the Plan, Granatelli, and NALAC is

AFFIRMED.

REAVLEY, Circuit Judge, concurring:

I agree with both of my colleagues that Tuneup Masters Employee Benefit Plan "does not incur any losses because of newborns with congenital defects, and the state is preempted by ERISA from requiring the Plan to include those losses." Having decided that matter, the NALAC policy, which only reimburses the Plan for claims paid in excess of $30,000, presents us with no legal questions and the Browns with no benefits. NALAC insures no one for any claim until the Plan has paid a claim in excess of $30,000. The Texas statute does not rewrite the contract between the Plan and NALAC to provide first dollar coverage, for newborns only, and neither should this court.

I concur in the affirmance.

JOHN R. BROWN, Circuit Judge, dissenting:

Prologue

I agree with the court that the plan does not cover newborns. Consequently the plan is not liable to the

Browns. My real point of difference is that, in my point of view, under Texas law,[1] the policy issued by NALAC is a group policy of accident or sickness insurance thus triggering Texas's mandatory coverage of newborns. Thus NALAC, independent of the plan, is liable to the Browns under its insurance policy.

* * * *

The court's opinion[2] allows insurance companies, authorized to carry on the business of insurance in Texas, which issue policies insuring employee benefit plans, to avoid the operation of the Texas Insurance Code and its mandatory coverage provisions. The court permits this result by characterizing the NALAC policy at issue here as a stop-loss policy. It then holds that this stop-loss policy is not an individual or group policy of accident or sickness insurance even though it acknowledges that the policy indirectly covers accident and sickness losses.

The court makes an attempt to close the loophole its opinion creates by saying it has looked beyond form to substance. It goes on to say that a stop-loss policy which has a stop-loss point of $500 would be treated differently from the policy at issue here, which had an attachment point of $30,000. In other words, a $500 stop-loss policy is insurance while a $30,000 stop-loss policy is not.

The framework thus derived is unacceptable on the facts of this case, contrary to the substance of the Texas

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[1] I claim no superior prescience to that of my colleagues, each of whom was a distinguished Texas practitioner and jurist, one of whom was a long time Justice on the court I urge be importuned if I am wrong or doubtfully correct on my reading of Texas law.

[2] References to "the court" or "the court's opinion" are primarily to the opinion of Judge Higginbotham. However, my dissent goes as well to Judge Reavley's short concurrence which I disagree with because (i) this case presents serious questions of both ERISA and Texas law, and (ii) I believe the Texas statute *does* rewrite NALAC's policy to include the mandated newborn coverage.

Insurance Code, and unworkable as a standard for future cases. For these reasons, I must respectfully dissent.

ERISA Saves State Regulation of Insurance Companies and Contracts

ERISA's broad pre-emption provision provides that:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title.

29 U.S.C. § 1144(a), ERISA § 514(a). However this pre-emption provision is modified by § 514(b), the "insurance savings clause," which provides in pertinent part:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A). Subparagraph (B) is the "deemer clause" which exempts *plans* from the operation of state laws regulating insurance. *See Metropolitan*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985).

This statutory scheme and *Metropolitan* pre-empt any state law from regulating the content of the Tuneup Masters Group Insurance Benefits Plan. Thus the Plan was not required to provide coverage for newborns and it is not structurally defective for failing to do so. I agree with the court that the *plan* itself does not provide any coverage for newborns. I agree also, that the plan cannot be held liable for its failure to include such coverage.[3] The Browns are not entitled to any recovery

[3] *See, e.g., Metropolitan*, 471 U.S. at 732-33, 105 S.Ct. at 2386-87, 85 L.Ed.2d at 735-36 ("[ERISA] does not regulate the substantive

against the plan. Thus the district court's entry of summary judgment in favor of the plan was correct.

However, the *plan* and the *policy* may be treated differently. The insurance savings clause leaves NALAC, an insurance company, subject to state law. It is not freed from compliance with Texas's mandated-benefits laws by the pre-emption or deemer clauses in ERISA. *Metropolitan*, 471 U.S. at 740-41, 105 S.Ct. at 2389, 85 L.Ed.2d at 741.

Texas Law Requires Newborn Coverage

Article 3.70-2(E) requires that

> [n]o individual policy or group policy of accident or sickness insurance, . . . which provides for accident and sickness coverage of additional newborn children or maternity benefits, may be issued . . . if it contains any provision excluding or limiting the initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child.

Tex.Ins.Code Ann. art. 3.70-2(E) (Vernon 1981).[4] The court takes the position that the NALAC policy, which it characterizes as a stop-loss policy, is not an "individual or group policy of accident or sickness insurance," and therefore that it need not comply with Art. 3.70-2(E).

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content of welfare-benefit plans.); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 91, 103 S.Ct. 2890, 2896, 77 L.Ed.2d 490, 497 (1983) ("ERISA does not mandate that employers provide any particular benefits.").

[4] Justice Blackmun informs us that "over the last 15 years all 50 States have required that coverage of infants begin at birth, rather than at some time shortly after birth, as had been the practice in the unregulated market." *Metropolitan*, 471 U.S. at 729, 105 S.Ct. at 2384, 85 L.Ed.2d at 733.

The *Metropolitan* Court informs us that:

> nothing in § 514(b)(2)(A), or in the "deemer clause" which modifies it, purports to distinguish between traditional and innovative insurance laws. The presumption is against pre-emption, and we are not inclined to read limitations into federal statutes in order to enlarge their pre-emptive scope. Further, there is no indication in the legislative history that Congress had such a distinction in mind. . . . *In short, the plain language of the saving clause, its relationship to the other ERISA pre-emption provisions, and the traditional understanding of insurance regulation, all lead us to the conclusion that mandated benefit laws . . . are saved from preemption by the operation of the saving clause.*

Metropolitan, 471 U.S. at 741-44, 105 S.Ct. at 2389-91, 85 L.Ed.2d at 741-43 (emphasis added). This is a clear indication that mandated benefit laws, like Art. 3.70-2 (E), are fully applicable to insurance policies and are not pre-empted by ERISA.

"Stop-loss" Coverage Insures a Plan

Unlike the court, and as my principal point of difference, I believe that, *as a matter of Texas, not ERISA*, law the NALAC policy *is* an insurance policy subject to the mandated benefit provision of Art. 3.70-2(E).[5] As

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[5] The only circuits which have addressed the specific question of whether a plan which purchases stop-loss insurance is an "insured" plan under *Metropolitan* such that a state's mandated benefits laws must be adhered to by the insurer are the Sixth and Ninth.

The Ninth Circuit held, in *Moore v. Provident Life & Acc. Ins. Co.*, 786 F.2d 922, 926-27 (9th Cir.1986), that the stop-loss insurer's function was not the "business of insurance." The claims were therefore pre-empted by ERISA and not saved by the insurance savings clause. This rationale was followed in *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir.1986). Several district courts have followed the direction of the Ninth Circuit *See, e.g., Drexelbrook Engineering Co. v. The Travelers Ins. Co.*, 710 F.Supp. 590 (E.D.Pa.1989), *aff'd without opinion*, 891 F.2d

the court points out, Texas law defines "accident and sickness insurance" very broadly as "any policy or contract providing insurance against loss resulting from sickness or from bodily injury or death by accident or both." Tex.Ins.Code Ann. art. 3.70-1(B)(3) (Vernon 1981). The NALAC policy provides such coverage. The plan reimburses employees for "eligible expenses" which are listed in a schedule of benefits. This schedule in-

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280 (3d Cir.1989); *Birdsong, et al. v. Olson, et al.*, 708 F.Supp. 792 (W.D.Tex.1989); *Rasmussen v. Metropolitan Life Ins. Co.*, 675 F.Supp. 1497 (W.D.La.1987); *Minnesota Chamber of Commerce & Industry v. Hatch*, 672 F.Supp. 393 (D.Minn.1987); *Bone v. Assoc. Management Services, Inc.*, 632 F.Supp. 493 (S.D.Miss.1986); *Cuttle v. Federal Employees Metal Trades Council*, 623 F.Supp. 1154 (D.Maine 1985); and *Hutchinson v. Benton Casing Service, Inc.*, 619 F.Supp. 831 (S.D.Miss.1985).

I believe the better reasoned approach is that adopted by the Sixth Circuit in *Michigan United Food and Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308, 312-13 (6th Cir.1985), *cert. denied*, 474 U.S. 1059, 106 S.Ct. 801, 88 L.Ed.2d 777 (1986) and *Northern Group Services, Inc. v. Auto Owners Insurance Co.*, 833 F.2d 85, 91 (6th Cir.1987), *cert. denied*, 486 U.S. 1017, 108 S.Ct. 1754, 100 L.Ed.2d 216 (1988). The Sixth Circuit found that the "stop loss" nature of the insurance purchased by the plans in those cases was irrelevant—the plans were insured.

> Whether the actual insured is the employer or the ERISA plan, the stop loss insurance is purchased to "provide benefits for plans subject to ERISA." *Metropolitan Life*, 471 U.S. at 738 n. 15, 105 S.Ct. at 2388 n. 15. That the plan pays a deductible does not alter the fact that benefits payable above specified levels, either on an individual beneficiary or in the aggregate, are nontheless insured. *See Baerwaldt*, 767 F.2d at 313.

Northern Group Services, 833 F.2d at 91. Several district courts have likewise followed this approach. *See, e.g., Hall v. Pennwalt Group Comprehensive Medical Expense Benefits Plan*, Civ. Action No. 88-7672, 1989 WL 45627 (E.D.Pa.1989) [1989 U.S. Dist. LEXIS 3018]; *Auto Club Ins. Assoc. v. Mutual Savings and Loan Assoc.*, 672 F.Supp. 997 (E.D.Mich.1987); *State Farm Mutual Automobile Ins. Co. v. American Community Mutual Ins. Co.*, 659 F.Supp. 635 (E.D.Mich.1987), *aff'd without opinion*, 863 F.2d 49 (6th Cir.1988); and *Simmons v. Prudential Ins. Co. of America*, 641 F.Supp. 675 (D.Colo.1986).

cludes many surgical procedures and other treatments that becomes necessary because of sickness or bodily injury.

It is of no importance that NALAC makes its payment to the plan, and not to the individual receiving the benefits. Once the Texas mandatory provision (Art. 3.70-2 (E)) broadens the policy's coverage to encompass newborns, the parents are obvious third party beneficiaries of the policy. NALAC is the source of funds, and NALAC's obligation to pay arises from the sickness or accident of a covered person. Thus NALAC's policy is one of "sickness or accident insurance" and by operation of mandatory Texas law covers newborns.

NALAC's Policy Was a "Group Policy" Under Texas Law

The court further contends that the NALAC policy is not an "individual policy or group policy," so NALAC does not have to comply with Article 3.70-2(E). Once again, I disagree. On my reading of the Texas statute, the NALAC policy has all the earmarks of a group insurance policy. By protecting the plan, NALAC is protecting sick and injured individuals of a defined group—the employees of Tuneup Masters.[6] The policy specifically refers to and relates to the plan. It is a "group policy" because it is

> (1) . . . a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer.

Tex.Ins.Code Ann. art. 3.51-6, sec. 1(a)(1) (Vernon 1990).

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[6] The Plan describes those covered as the "eligible Employees of the Employer and their eligible Dependents."

Thus I would hold that NALAC's so-called "stop-loss" policy is a group policy of accident and sickness insurance under Texas law. It is therefore statutorily modified to provide the newborn benefits mandated by Art. 3.70-2(E). The medical expenses incurred by the Browns' two infant children are covered. I would find the Browns entitled to recovery against NALAC which was sued as a named defendant in addition to the plan.[7] I would further hold that a $30,000 deductible on this coverage would make it invalid as contrary to the clearly expressed requirement in Texas of mandatory newborn coverage.

If in Doubt, Certainty is at Hand

Finally, if I am wrong on my reading of Texas law, we could and should secure an answer from the only court that can give us a definitive answer to this question of state law. We should certify the state law question to the Supreme Court of Texas.[8]

Because the court's opinion creates a system whereby insurance companies may avoid the operation of the Texas Insurance Code, I must respectfully dissent.

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[7] I re-emphasize that although on my reading of Texas law, the plan was an "insured" plan, no recovery is available against the plan. *Metropolitan* is very clear that state mandatory benefit laws are pre-empted by ERISA from directly regulating the content of a plan. Recovery is available only against NALAC, the insurer, which can be regulated by the state—even when insuring a plan—because of the savings clause which excepts it from ERISA's general pre-emption provision.

[8] Texas Rules of Appellate Procedure 114(a) states that a question of state law can be certified to the Supreme Court of Texas if "it appears to the certifying court that there is no controlling precedent in the decisions of the Supreme Court of Texas." *See Lucas v. United States*, 807 F.2d 414, 418 (5th Cir.1986).

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

Civil Action No. H-87-3310

JUDY C. BROWN and LEWIS F. BROWN, Individually and a/n/f of RIEDER P.M. BROWN, A Minor, and REISE G.L. BROWN, A Minor, Deceased,

Plaintiffs

vs.

ANDY GRANATELLI, As Trustee of TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN; THE TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN, and NORTH AMERICAN LIFE AND CASUALTY COMPANY, a/k/a NORTH AMERICAN LIFE AND CASUALTY INSURANCE COMPANY,

Defendants.

MEMORANDUM AND ORDER:

Pending are Plaintiffs' and Defendants' motions for summary judgment. After a thorough review of the pleadings, the briefs, ERISA, and the case law, the Court is of the opinion that Defendants' motions for summary judgment should be granted.

Statement of the Case

This is an action to recover benefits for two children under an employee welfare benefit plan. The plan was drafted to conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA). Mr. Granatelli as owner of Tuneup Masters purchased excess or stop-loss coverage from North Amer-

ican Life and Casualty Company (NALAC) for the benefit of the Plan for claims exceeding $30,000.00 for any individual.

The plan document which sets out the benefits and limitations of dependent coverage states,

> [A] newborn is not eligible for coverage until his/her 31th (sic) day of birth and any benefits hereunder will be subject to any Pre-Existing Limitations set forth in this Plan.

A pre-existing limitation included being disabled, hospitalized, or sick at the time the person would otherwise become eligible. The Browns' first child was born in January, 1986. He was premature and had physical problems. The Browns submitted claims for benefits and were denied benefits based on the "pre-existing conditions" of the infant. The Browns second child was born in November, 1986, also premature and with birth defects. He remained in the hospital until his death five months later. The Plan declined to pay benefits for this child also. The instant lawsuit was then filed.

Summary Judgment

Summary judgment is authorized if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Rule 56, Fed. R. Civ. P. The United States Supreme Court has interpreted this rule to mandate the entry of summary judgment after an adequate time for discovery against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial. *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986).

Discussion

The parties have agreed that there are no material issues of fact in dispute. Only the interpretation of the

law remains to be resolved. The Plaintiffs state three contentions that entitle them to judgment as a matter of law: "(a) because Defendant NALAC is compelled to provide coverage under Article 3.70-2, Tex. Ins. Code and 29 U.S.C. § 1144(b)(2)(A); (b) because any construction of the plan which denied benefits would render the Plan itself structurally defective; and (c) because Defendants' reading of the Plan is arbitrary and capricious as a matter of law.

Tuneup Masters contends that Plaintiffs' state law claims are preempted by ERISA and that, under ERISA, Plaintiffs can not prove that the Plan improperly denied Plaintiffs' claim for medical benefits.

NALAC contends that it is entitled to summary judgment because NALAC's duty only extended to stop-loss coverage for claims that were covered by the Plan. The Plan had no duty to pay these claims, so NALAC had no duty to provide excess coverage for them.

Plaintiffs allege that NALAC is an insurance company that provides insurance to the individuals insured by the Plan; the plan is insured; thus, NALAC must provide for newborn benefits as mandated by Texas law. Article 3.70-2, Tex. Ins. Code and 29 U.S.C. § 1144(b)(2)(A). This argument fails in the face of the Plan Document, ERISA, and prevailing case law. The Plan provides for benefits to the employees in the Plan up to $30,000.00 per employee. NALAC has contracted with Tuneup Masters to pay the employer for claims paid by the Plan in excess of $30,000.00. NALAC provides stop-loss coverage to Tuneup Masters for the benefit of the Plan. ERISA contains a pre-emption clause, a deemer clause, and a savings clause. "ERISA broadly pre-empts state laws that relate to an employee-benefit plan [that is self insured]. 29 U.S.C. § 1144(b)(2); *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 747, 105 S.Ct. 2380 (1985). The plan does not lose its status as an employee benefit plan merely because the employer

has acquired stop-loss coverage for the plan. *See Moore v. Provident Life and Accident Insurance Company*, 786 F.2d 922 (9th Cir. 1986). Texas' law mandating that newborns be covered by insurance policies is a law that relates to benefit plans and would be preempted unless it falls within one of the exceptions to the pre-emption clause of ERISA. Article 3.70-2 would not be pre-empted if the document in question is held to be insurance.

Plaintiffs concede that Article 3.70-2 does not apply to the Plan itself. They concede that the Supreme Court has held in *Metropolitan* that the Plan is governed by ERISA which pre-empts state law. But they claim their case is very similar to *Metropolitan*. Plaintiffs contend that Article 3.70-2 does apply to NALAC's policy because NALAC takes over payments for individuals after the plan has paid the first $30,000.00 thus making the plan insured. Plaintiffs contend that since the Plan is insured, NALAC's insurance policy must conform to state law. This is wrong. *Metropolitan*, the insurance company paid benefits directly to Massachusetts residents enrolled in Metropolitan's group policies. In contrast, NALAC never pays an employee directly. The employer must submit a claim to NALAC showing that the Plan has paid a claimant in excess of $30,00.00. NALAC then reimburses the employer for the benefit of the Plan. All payments by NALAC are made only to the employer. Defendants' Plan and stop-loss coverage are almost identical to the coverage supplied the plaintiff in *Moore v. Provident Life & Accident Insurance Company*, 786 F.2d 922, 924 (9th Cir. 1986). Like the situation in *Moore*, "Under the agreement [NALAC] provides only excess or "stop-loss" insurance to the [employer] when claims paid under the Plan exceed a specified aggregate amount in any year." *Id.* The court in *Moore* held that Provident was not an insurance company to the Plan.

> The administrative privileges retained by Provident are not related to the business of insurance and are

> not within the contemplation of ERISA's insurance savings clause.

Id. at 927.

This case law has been cited with approval in this Circuit in discussing the liability of a stop-loss coverage policy. The Courts have held the

> savings clause not applicable to former employee's state law claims for recovery of benefits and punitive damages against an insurance company from which an employee benefit plan purchased stop-loss insurance since the insurance company's role in relation to the benefit plan *insofar as plaintiff's claims were involved* was merely as an administrative overseer since the stop-loss coverage did not go into effect. (emphasis added)

Rasmussen v. Metropolitan Life Insurance Co., 675 F. Supp. 1497, 1502 (W.D. La. 1987), citing *Moore, supra*, and *Hutchison v. Benton Casing Service, Inc.*, 619 F.Supp. 831, 836-39 (S.D. Miss. 1985).

Thus, it is clear that NALAC is not an insurance company as defined by ERISA. NALAC is not compelled to conform to state mandated benefit laws.

Plaintiffs next contend that any construction of the Plan which denies the requested benefits renders the plan structurally defective, or that the Defendants' reading of the Plan is arbitrary and capricious as a matter of law. Both of these arguments must also fail because a careful reading of the Plan Document reveals clearly that newborn infants are not covered for the first 30 days after birth and are then subject to the pre-existing-condition clause before being eligible for coverage.

The Plaintiffs contend that the initial summary of the plan they received from Tuneup Masters—the booklet—conflicts with the Plan Document—the Document—in many material aspects. Plaintiffs have either not read

the two documents, or they are deliberately trying to mislead the Court. It is true that both the booklet and the document require a careful, thorough review to be understood. The Court has given both the necessary review and finds that in the final analysis they both hold that newborns are not covered for the first 30 days.

On page 1 of the booklet, it is stated that, "coverage for a newborn will become effective on the 30th day of birth. On page 2, it goes on to state,

> Eligible dependents will not include . . . any dependent who is disabled, hospitalized or sick on the date coverage would otherwise become effective.

Finally, Plaintiffs wish to prevail on the statement on page 12,

> Infant post-natal care expenses are not covered, other than those for sickness or bodily injury of such infant.

It is clear that the effective date of coverage for a newborn is the 30th day after birth. But, on the 30th day, the newborn must be eligible to be covered. Only after the 30th day, as stated on page 12, does the Plan begin to cover infants for sickness and bodily injury. Contrary to Plaintiffs' contention, on page 30 of the booklet specifically refers to the Plan Document. It states that Plan participants are entitled to obtain copies of all Plan documents and other Plan information.

The Plan document makes it crystal clear on page 29 that,

> [A] newborn is not eligible for coverage until his/her 31th (sic) day of birth and any benefits hereunder will be subject to any Pre-Existing Limitations set forth in this Plan.

The Court has read and reread the booklet and the document. However painful it is, the Court must find

that Tuneup Masters and Andy Granatelli as the trustee have chosen to exclude newborns from coverage by the Plan. The Plan is not in conflict with ERISA or Federal or State Regulations. It has no legal duty to cover any specific group, injury, or illness. The drafters of the Plan chose to cover some illnesses and injuries and to exclude others for the good of all Plan participants. The Plan is not defective. An objective reading of the Plan concerning coverage for newborn babies does not allow for any interpretation, much less one that is arbitrary and capricious. The plain words and their usually understood meaning show that newborns are not covered.

For the reasons stated above, it is therefore

ORDERED that Defendants' motions for summary judgment are GRANTED and Plaintiffs' motion for summary judgment is DENIED.

Signed at Houston, Texas, this 26th day of Jan., 1989.

/s/ Norman W. Black
NORMAN W. BLACK
United States District Judge

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

Civil Action No. H-87-3310

JUDY C. BROWN and LEWIS F. BROWN, Individually and a/n/f of RIEDER P.M. BROWN, A Minor, and REISE G.L. BROWN, A Minor, Deceased,

Plaintiffs

vs.

ANDY GRANATELLI, As Trustee of TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN; THE TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN, and NORTH AMERICAN LIFE AND CASUALTY COMPANY, a/k/a NORTH AMERICAN LIFE AND CASUALTY INSURANCE COMPANY,

Defendants.

FINAL JUDGMENT

For the reasons stated in the attached Memorandum and Order, it is

ORDERED that Defendants' motions for summary judgment are GRANTED and Plaintiffs' motion for summary judgment is DENIED.

Each party to pay their own costs.

This is a FINAL JUDGMENT.

Signed at Houston, Texas, this 26th day of Jan., 1989.

/s/ Norman W. Black
NORMAN W. BLACK
United States District Judge

(2)

No. 90-72

In The

Supreme Court of the United States

October Term, 1990

JUDY C. BROWN AND LEWIS F. BROWN, INDIVIDUALLY AND AS NEXT FRIENDS OF REIDER P. M. BROWN, A MINOR, AND REISE G. L. BROWN, A MINOR, DECEASED,

Petitioners,

vs.

ANDY GRANATELLI, AS TRUSTEE OF TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN; THE TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN, AND NORTH AMERICAN LIFE AND CASUALTY COMPANY,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

TERRY PRICE*
Counsel of Record for Respondents Andy Granatelli and The TuneUp Masters, Inc. Employee Benefit Plan.
CONSTANGY, BROOKS & SMITH
2400 Peachtree Center Building
230 Peachtree Street, N.W.
Atlanta, Georgia 30303
(404) 525-8622

*Counsel of Record

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

QUESTIONS PRESENTED

1. Whether Petitioners are precluded from asserting that the Plan and its Trustee are liable for the medical expenses of Reider and Reise Brown when Petitioners have conceded in the lower courts that Tex. Ins. Code Ann. Art. 3.70-2(E) does not apply to the Plan and that if Art. 3.70-2(E) did apply directly to the Plan, its application would be preempted by the Employee Retirement Income Security Act.

2. Whether Section 514 of the Employee Retirement Income Security Act preempts the application and enforcement of Tex. Ins. Code Ann. Art. 3.70-2(E) to a self-insured employee health benefit plan.

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No. 90-72

In The

Supreme Court of the United States

October Term, 1990

JUDY C. BROWN AND LEWIS F. BROWN, INDIVIDUALLY AND AS NEXT FRIENDS OF REIDER P. M. BROWN, A MINOR, AND REISE G. L. BROWN, A MINOR, DECEASED,

Petitioners,

vs.

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Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

STATEMENT OF THE CASE

Since 1980, TuneUp Masters, Inc. ("TuneUp Masters")[1] has maintained a self-insured health plan for certain employees and their beneficiaries as defined therein. TuneUp Masters, Inc. purchased excess or "stop-loss" coverage from North American Life and Casualty Company ("NALAC"). Under the contract with NALAC, NALAC reimburses the Plan for claims the Plan pays which exceed $30,000 for any plan participant or beneficiary during the contract year.

In 1985, the Plan was amended in response to escalating medical costs, including the large expenses of premature births which would likely affect TuneUp Masters' ability to maintain its plan for the benefit of all of its covered employees. The plan amendment, among other things, established a 30-day waiting period for coverage of newborns and made newborn coverage subject to the pre-existing limitation provisions of the Plan. The plan amendment was described in a 1985 Summary Plan Description ("SPD"), which was then distributed to employees.

In January of 1986, Judy C. Brown gave birth to a child who, according to medical claims submitted by Lewis Brown (one of TuneUp Masters's employees who had received a copy of the 1985 SPD), was born prematurely and required and was given extensive medical care and treatment. As medical bills were received by the

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[1] The holding company for TuneUp Masters is XPERT/TUM Acquisition, Inc. TuneUp Masters does not have any non-wholly owned subsidiaries.

Plan they were denied because the expenses either were incurred during the 30-day waiting period or because of the child's pre-existing disabilities and hospital confinement. In November of 1986, Judy C. Brown gave birth to another child who, according to medical claims submitted by Lewis Brown, was born prematurely, had birth defects and required and was given extensive medical care and treatment. Similarly with respect to the second child, as medical bills were received by the Plan they were denied for the same reasons.

Petitioners filed suit in state court against, among others, the Plan and Mr. Granatelli. The defendants removed the case to federal district court because of the federal question involved. Petitioners subsequently amended their Complaint to assert claims against only the Plan and Mr. Granatelli, as Trustee of the Plan, and added NALAC as a defendant.

The parties stipulated that there were no genuine issues of material fact and moved for summary judgment. Petitioners conceded that Tex. Ins. Code Ann. Art. 3.70-2(E) does not apply to the Plan itself. (See Petition for Writ of Certiorari, Appendix B, p. 19a). Tex. Ins. Code Ann. Art. 3.70-2(E) provides:

> No individual policy or group policy of accident or sickness insurance, including policies issued by companies subject to Chapter 20, Texas Insurance Code, as amended, delivered or issued for delivery to any person in this state which provides for accident and sickness coverage of additional newborn children or maternity benefits, may be issued in this state if it contains any provision excluding or limiting initial coverage of a newborn infant for a period of time, or

limitations or exclusions for congenital defects of a newborn child.

After due consideration of the parties' motions, the District Court granted summary judgment to the Plan, its Trustee, and NALAC and denied Petitioners' motion for summary judgment which contended that the Plan was, among other things, structurally defective.

On appeal, Petitioner admitted that if Art. 3.70-2(E) applied directly to employee benefit plans, its application would be preempted by ERISA. (See Petition for Writ of Certiorari, Appendix A, pp. 3a-4a). The Fifth Circuit, after hearing oral argument, rendered its judgment on April 11, 1990, affirming the judgment of the district court. *Brown v. Granatelli*, 897 F.2d 1351 (5th Cir. 1990).

SUMMARY OF ARGUMENT

Respondents Andy Granatelli, Trustee of the TuneUp Masters, Inc. Employee Benefit Plan, and the TuneUp Masters, Inc. Employee Benefit Plan respectfully submit (1) that this case does not raise a federal question warranting review by the Court, 2) that the Circuit Courts that have considered the issue whether ERISA preempts state insurance laws that attempt to mandate the injuries and illnesses to be covered by self-insured employee health benefit plans, have decided that such state laws are preempted by ERISA and (3) that the law in those Circuits that have considered this issue is consistent with the precedent of the Court and Section 514 of ERISA. Accordingly, Respondents respectfully submit that Petitioners' Petition For Writ of Certiorari should be denied.

REASONS FOR NOT GRANTING THE WRIT

I. THE DECISION OF THE FIFTH CIRCUIT IS IN ACCORD WITH GOVERNING STATUTORY LAW AND THE PRECEDENT OF THIS COURT

ERISA preempts all state laws that attempt to regulate the content of employee benefit plans. Section 514 of ERISA provides, in part:

> **[The Preemption Clause]**
>
> Except as provided in subsection (b) of this section [the Saving Clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975. [Section 514(a), as set forth in 29 U.S.C. § 1144(a)].
>
> **[The Saving Clause]**
>
> Except as provided in subparagraph (B) [the Deemer Clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. [Section 514(b)(2)(A), as set forth in 29 U.S.C. § 1144(b)(2)(A)].
>
> **[The Deemer Clause]**
>
> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or

> to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. [Section 514(b)(2)(B), as set forth in 29 U.S.C. 1144(b)(2)(B)].

Thus, if a state law relates to an employee benefit plan it is preempted, unless the law regulates an insurance company engaged in the business of insurance; however, state law cannot regulate an employee benefit plan by deeming the plan to be an insurance company or engaged in the business of insurance, unless such plan's primary purpose is to provide death benefits (*i.e.*, life insurance). Since the plan at issue in this case does not provide death benefits, the Deemer Clause protects this plan from state regulation.

In *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), the Court decided the question whether ERISA preempts a Massachusetts statute requiring insurance companies to provide mental-health coverage in certain types of insurance policies. Although the Massachusetts statute was drafted broadly enough to require that self-insured plans provide the mandated mental-health benefits, "[i]n light of ERISA's 'deemer clause,' § 514(b)(2)(B), 29 USC § 1144(b)(2)(B) [29 USCS § 1144(b)(2)(B)], which states that a benefit plan shall not 'be deemed an insurance company' for purposes of the insurance saving clause, Massachusetts has never tried to enforce § 47B [the mental-health coverage mandate] as applied to benefit plans directly, effectively conceding that such an application of § 47B would be preempted by ERISA's pre-emption clause, § 514(a), 29 USC § 1144(a)

[29 USCS § 1144(a)]." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 735 n.14. Although the Court did hold that the State of Massachusetts could regulate insurance companies and the content of the insurance policies that the insurance companies sell, the Court noted that the effect of the Deemer Clause is that the insurance Saving Clause cannot be used to regulate an employee benefit plan. 471 U.S. at 747 n.25.

Thus, the Fifth Circuit's decision that Tex. Ins. Code Ann. Art. 3.70-2(E) cannot be applied to the Plan and its Trustee is consistent with governing statutory law and the precedent of this Court.

Moreover, Petitioners admitted in the District Court and in the Fifth Circuit that Art. 3.70-2(E) does not apply to the Plan itself and that if Art. 3.70-2(E) applied directly to the Plan, its application would be preempted by ERISA. Accordingly, Respondents respectfully submit that Petitioners' Petition for a Writ of Certiorari is due to be denied.

II. THERE IS NO CONFLICT AMONG THE CIRCUIT COURTS – STATE INSURANCE LAWS CANNOT MANDATE THOSE INJURIES AND ILLNESSES TO BE COVERED BY SELF-INSURED EMPLOYEE HEALTH BENEFIT PLANS

Contrary to Petitioners' assertion, there is no conflict among the Sixth, Ninth and Fifth Circuits on the question whether state insurance law may mandate the injuries and illnesses covered by an employee health benefit plan. Petitioners cite *Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985),

cert. denied, 474 U.S. 1059 (1986), and *Moore v. Provident Life & Accident Insurance Co.*, 786 F.2d 922 (9th Cir. 1986), as the basis for their assertion that there is such a conflict.

The Sixth Circuit's *Baerwaldt* decision is not in conflict with the Ninth Circuit's *Moore* decision or the Fifth Circuit's decision in this case. The *Baerwaldt* case involved the application of a state mandated coverage requirement to a group health insurance contract; whereas the *Moore* case involved the application of a state law claims processing requirement to an employee health benefit plan, and the plan's third party administrator and the "stop-loss" carrier.

Furthermore, the law in the Sixth Circuit is exactly the same as the law in the Fifth Circuit – namely, that state laws which regulate the content of employee benefit plans are preempted by ERISA. *Liberty Mut. Ins. Group v. Iron Workers Health Fund*, 879 F.2d 1384 (6th Cir. 1989). Accordingly, Petitioners' reliance on the Sixth Circuit's decision in *Baerwaldt*, is misplaced.

In *Baerwaldt*, the sole ERISA issue before the court was whether a Michigan insurance statute could be applied to group health insurance policies sold by an insurance company to employee benefit plans. Michigan Public Act No. 429 requires each insurer offering group and individual health insurance policies within the State of Michigan to include substance abuse coverage within those policies. Two employee benefit plans and their trustees sued the Michigan Bureau of Insurance, Michigan's Commissioner of Insurance and the Deputy Commissioners of Insurance for declaratory and injunctive relief. The lawsuit was triggered by the insurer's telling

the plans of the insurer's concern that the insurer would lose its ability to do business in Michigan unless the health plans were amended to include coverage for substance abuse. Although the Sixth Circuit did hold that Act No. 429 could be applied to the insurer's group health insurance policies, the court did not hold that Act No. 429 could be applied to the plans themselves. The court's comment that the "stop-loss" nature of the plans did not alter the court's conclusion does not mean that the court held that Act No. 429 could be applied to the plans themselves. The comment means merely that the "stop-loss" nature of the plans did not prevent the State of Michigan from applying Act No. 429 to the insurer's group health insurance policies.

The Sixth Circuit's *Baerwaldt* decision is not in conflict with the Ninth Circuit's *Moore* decision. In *Moore*, a former employee sued his former employer, the insurance company which provided administrative services and "stop-loss" coverage for the employer's employee health benefit plan, the Administrator of the plan and the Trustees of the plan for breach of covenant of good faith and fair dealing, fraud, breach of fiduciary duties under California law and ERISA, and violation of California Insurance Code § 790.03. Although the terms and provisions of the health benefit plan were drawn from a group health policy used by the insurance company, the insurance company's undertaking was merely to provide administrative services (*i.e.*, determining benefits and paying claims from the plan's trust fund) for the plan and to reimburse the plan's trust fund after the trust fund had paid a specified aggregate amount of claims. Since the specified aggregate amount of paid claims was not

reached by the trust fund, the insurance company did not have an obligation to reimburse the trust fund during the period when Moore's claims were being made. In addition to holding that the Deemer Clause of ERISA bars the application of the Saving Clause of ERISA to an employee benefit plan, the court held that Moore's common law causes of action were preempted by ERISA. Also, the court held that California Insurance Code § 790.03 was preempted by ERISA because it did not regulate the business of insurance in that the statute has nothing to do with the spreading of risks, but is simply directed at administrative claims processing. Moreover, the court held that the state law claims against the insurance company (for purely administrative claims processing functions) were not based on laws regulating the activities of an insurance company engaged in the business of insurance.

Since *Baerwaldt*, the Sixth Circuit has issued a series of decisions clarifying the law. In the Sixth Circuit, state laws which attempt to mandate those injuries and illnesses to be covered by employee health benefit plans are preempted by ERISA.

When this case was before the Fifth Circuit and the district court, petitioners cited the Sixth Circuit's decision in *Northern Group Services v. Auto Owners Insurance Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017 (1988), for the proposition that state statutes regulating the types of coverage required in certain insurance policies are not preempted by ERISA even as applied to employee health benefit plans. *Northern Group Services* involved the narrow issue whether a Michigan no-fault automobile insurance law requiring that automobile

insurance policies contain coordination of benefit provisions could be preempted by ERISA to the extent such state law conflicts with coordination of benefit rules contained in certain employee health benefit plans. Coordination of benefit rules determine who pays first when multiple coverages apply to the same injury or illness. Under Michigan law, no-fault automobile insurance coverage is secondary to other health and accident coverage. The court held that ERISA did not necessarily preempt the entire field of such coordination of benefit rules and remanded the case to the district court. The Sixth Circuit, drawing a distinction between state laws that regulate the content of a plan and state laws that may merely affect the order of payment from a plan, pointed out at 833 F.2d at 93 that its decision did not apply to state laws that attempt to mandate the types of coverage provided by an employee benefit plan, which laws remain preempted by ERISA. On remand, the district court held that the Sixth Circuit had ruled that Michigan's coordination of benefit rules apply to self-insured health benefit plans as a matter of state law. The case was again appealed to the Sixth Circuit. The Sixth Circuit reversed the trial court and stated that the Sixth Circuit's earlier decision in *Northern Group Services* had not decided the issue whether Michigan's coordination of benefit rules apply to self-insured health plans. *Northern Group Servs. v. State Farm Mut. Auto. Ins. Co.*, 898 F.2d 1125 (6th Cir. 1990).

Before issuing its second decision in *Northern Group Services*, the Sixth Circuit had already confronted the question whether ERISA preempts the application of state mandated coverage laws to employee health benefit plans. In *Liberty Mutual Insurance Group v. Iron Workers*

Health Fund, 879 F.2d 1384 (6th Cir. 1989), an insurance company that had issued a no-fault automobile policy sued an employee health benefit plan which specifically excluded coverage for expenses resulting from automobile accidents. The insurance company argued that Michigan's automobile no-fault coordination of benefit provision (the same one at issue in the *Northern Group Services, Inc.* case) not only requires other health and accident coverage providers to pay first, but also prohibits employee health benefit plans from excluding coverage for expenses resulting from automobile accidents. The Sixth Circuit stated that if the Michigan Supreme Court were to interpret that the no-fault insurance law required employee benefit plans to provide coverage for automobile accident injuries, such state law would be preempted by ERISA. Thus, the Fifth Circuit's decision in this case is consistent with the law of the Sixth Circuit.

While the Court has granted a Petition for a Writ of Certiorari in *FMC v. Holliday*, 885 F.2d 79 (3d Cir. 1989), *cert. granted*, 58 U.S.L.W. 3513 (U.S. February 20, 1990) (No. 89-1048), Respondents respectfully submit that the Third Circuit's decision in that case does not create a conflict between the Third and Fifth Circuits on the issues presented in this case. In *FMC*, a child of an employee of FMC Corporation ("FMC") was injured in an automobile accident. FMC's self-insured health plan contained a subrogation clause requiring, among other things, the execution of a reimbursement agreement before the plan would process claims where there was potential liability on the part of a third-party. Thus, to obtain reimbursement from the plan for his child's injuries, the employee signed a third-party reimbursement form. The plan then paid the

medical expenses incurred on behalf of the child. When the plan discovered that the employee had initiated a negligence action, the plan notified the employee that the plan intended to pursue its subrogation rights. The employee responded that 75 Pa. Cons. Stat. Ann. § 1720 of the Pennsylvania Motor Vehicle Law prohibits such subrogation. Section 1720 provides:

> In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits in lieu thereof paid or payable under section 1719 (relating to coordination of benefits).

FMC responded by bringing an action seeking a declaratory judgment that it was entitled to subrogation.

The district court held that FMC's subrogation claim was barred by § 1720 and that § 1720 was not preempted by ERISA.

On appeal, the Third Circuit held that § 1720 applied to FMC's health plan. Also, the Third Circuit held that although § 1720 relates to employee benefit plans within the meaning of ERISA, § 1720 is saved from preemption under ERISA's Saving Clause because § 1720 regulates insurance contracts. Moreover, relying on the Sixth Circuit's first decision in *Northern Group Services*, the Third Circuit held that the Deemer Clause does not bar the application of § 1720 to self-insured health plans because subrogation is not a core ERISA concern.

Importantly, *FMC* was argued in the Third Circuit just six days after the Sixth Circuit's decision in *Liberty Mutual Insurance Group*. Also, *FMC* was decided by the Third Circuit long before the Sixth Circuit issued its second decision in *Northern Group Services*. Thus, the Third Circuit may have read more into the Sixth Circuit's first decision in *Northern Group Services* than the Sixth Circuit had originally intended (as did the district court on the first remand of *Northern Group Services)*. Moreover, since *FMC* does not involve the issue whether state insurance laws can mandate those injuries and illnesses to be covered by an employee health benefit plan, the Third Circuit could decide, as has the Sixth Circuit, that ERISA preempts state insurance laws that mandate those injuries and illnesses to be covered by an employee health benefit plan. Finally, *FMC* is distinguishable from this case because (1) Petitioners have conceded in the district court and in the Fifth Circuit that Tex. Ins. Code Ann. Art. 3.70-2(E) does not apply to the plan itself and (2) the Fifth Circuit has held that Tex. Ins. Code Ann. Art. 3.70-2(E) does not cover "stop-loss" insurance contracts. Accordingly, Respondents respectfully submit that Petitioners' concession obviated a decision on the federal preemption issue and that the Fifth Circuit's decision on the scope of Art. 3.70-2(E) does not raise an issue warranting review by the Court.

III. PETITIONERS' CONTENTION THAT THE USE OF PLAN ASSETS TO PURCHASE "STOP-LOSS" COVERAGE IS A PER SE VIOLATION OF ERISA DOES NOT WARRANT REVIEW

In the District Court, Petitioners neither raised nor proved their current contention that it is illegal for plan

assets to be used to purchase "stop-loss" coverage. Accordingly, Respondents respectfully submit that Petitioners' contention does not warrant the granting of a Writ of Certiorari. *Youakim v. Miller*, 425 U.S. 231 (1976).

Moreover, Petitioners have not provided and cannot provide any logical argument or any authority that supports their contention that 29 U.S.C. § 1103(c)(1)[2] is violated by using plan assets to purchase "stop-loss" coverage. "Stop-loss coverage protects the financial viability of a self-insured employee health benefit plan by reimbursing the plan for catastrophic losses.

IV. CONCLUSION

Respondents Andy Granatelli, Trustee of the TuneUp Masters, Inc. Employee Benefit Plan, and the TuneUp Masters, Inc. Employee Benefit Plan respectfully pray that the Petition for Writ of Certiorari be denied. There is no conflict among the Circuit Courts regarding whether a state mandated coverage law may be applied to self-insured employee health benefit plans. Moreover, the

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[2] 29 U.S.C. § 1103(c)(1) provides:

> Except as provided in paragraph (2), (3) or (4) or subsection (d) of this section, or under sections 1342 and 1344 of this title (relating to termination of insured plans), the assets of a plan shall never inure to the benefit of any employer and shall be held for the exclusive purposes of providing benefits to participants in the plan and their beneficiaries and defraying reasonable expenses of administering the plan.

Fifth Circuit's decision in this case is in accord with the precedent of this Court. Accordingly, Respondents respectfully submit that there is no special or important reason to grant a Writ of Certiorari and that Petitioners' Petition should be denied.

Respectfully submitted,

TERRY PRICE*
Counsel of Record
for Respondents Andy Granatelli and The TuneUp Masters, Inc. Employee Benefit Plan.
CONSTANGY, BROOKS & SMITH
2400 Peachtree Center Building
230 Peachtree Street, N.W.
Atlanta, Georgia 30303
(404) 525-8622

*Counsel of Record

GARY B. LAWSON
GODWIN, CARLTON & MAXWELL
3300 NCNB Plaza
901 Main Street
Dallas, Texas 75202
(214) 939-4400

(3)

AUG 10 1990

JOSEPH F. SPANIOL, JR.
CLERK

No. 90-72

IN THE

Supreme Court of the United States

October Term, 1990

JUDY C. BROWN and LEWIS F. BROWN, Individually and As Next Friends of REIDER P. M. BROWN, A Minor and REISE G. L. BROWN, A Minor, Deceased
Petitioners

vs.

ANDY GRANATELLI, As Trustee of TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN, THE TUNEUP MASTERS, INC. EMPLOYEE BENEFIT PLAN, and NORTH AMERICAN LIFE AND CASUALTY COMPANY
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF IN OPPOSITION OF RESPONDENT NORTH AMERICAN LIFE AND CASUALTY COMPANY

JAMES J. MCCONN
Counsel of Record

NAOMI S. OSTFELD
SUSAN C. STEVENSON
HAYS, MCCONN, PRICE & PICKERING
400 Citicorp Center
1200 Smith Street
Houston, Texas 77002
(713) 654-1111

Counsel for Respondent

RESTATEMENT OF THE QUESTIONS PRESENTED

1. Whether this Court should review the court of appeals' decision based solely upon its interpretation of Texas statutes, where Petitioners have not contended that the court of appeals' interpretation of state law was erroneous.

2. Whether there is a sufficient basis for review by this Court of the court of appeals' decision based upon an alleged conflict among the circuit courts of appeals regarding the impact of stop-loss insurance upon a self-insured employee benefit plan.

Federal Statutes:

Texas Statutes:

No. 90-72

IN THE

Supreme Court of the United States

October Term, 1990

JUDY C. BROWN and LEWIS F. BROWN, Individually
and
As Next Friends of REIDER P. M. BROWN, A Minor
and REISE G. L. BROWN, A Minor, Deceased
Petitioners,

vs.

ANDY GRANATELLI, As Trustee of
TUNEUP MASTERS, INC.
EMPLOYEE BENEFIT PLAN,
THE TUNEUP MASTERS, INC.
EMPLOYEE BENEFIT PLAN, and NORTH
AMERICAN LIFE AND CASUALTY COMPANY,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE
FIFTH CIRCUIT

BRIEF IN OPPOSITION OF RESPONDENT NORTH AMERICAN LIFE AND CASUALTY COMPANY

Respondent, North American Life and Casualty Company (hereinafter "NALAC"), respectfully requests this Court to deny the Petition for Writ of Certiorari, seeking review of the opinion of the United States Court of Appeals for the Fifth Circuit rendered on April 11, 1990. That opinion is reported at 897 F.2d 1351.

OPINIONS BELOW

NALAC does not contest the statement of the opinions of the United States District Court for the Southern District of Texas and of the United States Court of Appeals for the Fifth Circuit set forth in the Petition for Writ of Certiorari.

STATEMENT OF JURISDICTION

NALAC does not contest the statement of jurisdictional grounds set forth in the Petition for Writ of Certiorari.

STATEMENT OF THE CASE

Petitioners contend that the TuneUp Masters, Inc. Employee Benefit Plan (the "Plan") is an insured plan. *See* Petition for Writ of Certiorari at 5. However, the Plan is actually a self-insured group medical plan established in 1980 by TuneUp Masters, Inc. ("TuneUp Masters") to provide certain health care benefits for its eligible employees and their dependents. The Plan is an employee welfare benefit plan within the meaning of Title I of the Employee Retirement Income Security Act of 1974 (hereinafter "ERISA"), 29 U.S.C. §1002(1) and (3). At all times material to this case, the Plan was administered by First Fund Insurance Administrators, Inc. ("First Fund"), which was solely responsible for processing and paying claims submitted by TuneUp Masters' employees and their dependents under the Plan.

The Plan is covered by an excess risk insurance policy (the "Policy") issued by NALAC to the NALAC Employers Insurance Trust TuneUp Masters, Inc. (the "Policyholder"). The Policy provides stop-loss coverage which reimburses the Plan for the amounts the Plan pays out in claims for each covered person in excess of $30,000 per Policy Year, not to exceed the Plan's total lifetime maximum per covered person of $250,000. NALAC has no authority to either approve or deny claims under the Plan or to amend the Plan.

In response to rapidly escalating benefit payments, due primarily to large expenses incurred in connection with the treatment of a premature baby born to another employee of TuneUp Masters, TuneUp Masters amended the Plan effective February 1, 1985, by adding various cost containment measures. Among these measures was a 30-day waiting period before newborn babies would be covered under the Plan. Any medical condition which arose before the expiration of the 30-day waiting period would be subject to the total disability and preexisting condition provisions of the Plan. A new Summary Plan Description which described these

changes was prepared in 1985 and distributed to TuneUp Masters' employees.

On January 5, 1986, Petitioner Judy C. Brown gave birth to Reider Brown, who was premature and suffered from medical problems related to his premature birth. On November 24, 1986, Judy C. Brown gave birth to Reise Brown, who also was premature and suffered from birth defects as well as other medical problems related to his premature birth. Reise died after five months. First Fund, on behalf of the Plan, denied Petitioners' claims for payment of their medical bills for the treatment of Reider and Reise Brown because the expenses were incurred either during the 30-day waiting period or during the time that Reider and Reise were excluded because of their hospital confinement under the total disability provision or the preexisting condition provision. The claim denials by First Fund were reviewed by the Plan's Trustees, who affirmed First Fund's decision.

Petitioners filed suit in the 133rd District Court of Harris County, Texas against Andy Granatelli, as Trustee of the Plan, the Plan itself, and others, to recover benefits under the Plan. Respondents removed the case to the United States District Court for the Southern District of Texas, Houston Division, pursuant to 28 U.S.C. §1441(a), based upon 28 U.S.C. §1331 (federal question jurisdiction) because the Petitioners' claim arose under and is governed exclusively by the provisions of ERISA. Thereafter, NALAC was added as a party defendant.

Since all parties agreed that there was no dispute regarding the facts in the case, Petitioners and Respondents filed cross-Motions for Summary Judgment. On January 30, 1989, the district court entered a Memorandum and Order and a Final Judgment granting Respondents' Motions for Summary Judgment and denying Petitioners' Motion for Summary Judgment.

Petitioners timely appealed to the United States Court of Appeals for the Fifth Circuit. Petitioners admitted " . . . that if Article 3.70-2(E) by its letter applied directly to employee benefit plans, its application would be preempted by ERISA." *Brown v. Granatelli*, 897 F.2d at 1353. Petitioners' issue was whether Tex. Ins. Code Art. 3.70-2(E) applied to the Plan indirectly through the stop-loss Policy.

After hearing oral argument, the court of appeals on April 11, 1990, affirmed the decision of the district court by holding that Art. 3.70-2(E) does not apply to the Policy for reasons based upon its interpretation of Texas statutes. For the reasons discussed below, the Petition for Writ of Certiorari should be denied.

REASONS WHY THE PETITION SEEKING DISCRETIONARY REVIEW SHOULD BE DENIED

The court of appeals' decision in *Brown* was based upon its interpretation of a Texas statute, Tex. Ins. Code Art. 3.70-2(E). As a result, the court did not have to decide any of the ERISA issues. Petitioners have not cited any cases which show that the court's interpretation of the Texas statute is erroneous. In fact, the Petitioners do not even refer to either the court of appeals' decision or Tex. Ins. Code Art. 3.70-2(E) in their "Questions Presented for Review" and "Reasons for Granting the Writ". Consequently, this Court has no reason to review the court of appeals' interpretation of Tex. Ins. Code Art. 3.70-2(E).

Petitioners imply in their "Reasons for Granting the Writ" that there is a conflict among the circuits regarding the impact of stop-loss insurance, although they do not raise that as a question for review. Since the court of appeals concluded that it did not have to reach the federal question regarding stop-loss insurance, this case does not affect the alleged conflict. In addition, a careful review of the cases cited by Petitioners shows that, in any event, there is no conflict among the circuits regarding stop-loss insurance.

Petitioners' final two "Questions Presented for Review" relate to extra-contractual causes of action and preemption by ERISA. These issues were never reached by either the district court or the court of appeals in their decisions. Therefore, there is no lower court decision regarding these questions for this Court to review.

I. THE COURT OF APPEALS FOR THE FIFTH CIRCUIT BASED ITS DECISION UPON TEXAS STATUTES, AND ITS INTERPRETATION OF TEXAS LAW IS NOT ERRONEOUS

The Petitioners admitted before the court of appeals that Tex. Ins. Code Art. 3.70-2(E) did not apply directly to the Plan. However, Petitioners argued that the Texas statute could be applied indirectly to the Plan through the stop-loss Policy issued by NALAC. Article 3.70-2(E) states that:

> "[n]o individual policy or group policy of accident and sickness insurance . . . delivered or issued for delivery to any person in this state which provides for accident and sickness coverage of additional newborn children or maternity benefits, may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child."

The court of appeals held that Art. 3.70-2(E) does not apply to a stop-loss policy. The court first reviewed the purpose of Subchapter G of the Texas Insurance Code:

> "The focus of Subchapter G is on protecting sick or injured individuals; Subchapter G has nothing to say about protecting employee benefit plans from catastrophic loss. The statement of purpose in Subchapter G is illustrative. It states:
>
> > 'The purpose of the Act shall be to provide for reasonable standardization, readability, and simplification of terms and coverages contained in individual accident and sickness insurance policies; to facilitate public understanding of coverages; to eliminate provisions contained in individual accident and sickness insurance policies which may be unjust, unfair, misleading, or unreasonably confusing in connection with the purchase of such coverages or with settlement of claims; and to provide for full and fair disclosure, in the sale of accident and sickness coverages.'
>
> Tex. Ins. Code Ann. Art. 3.70-1 (Vernon 1981)."

897 F.2d at 1354. The court did not believe that stop-loss insurance, which is intended to insure an employee benefit plan, rather than insuring the employee benefit plan participants directly, fell within the purpose espoused by the Texas legislature. "By adopting words of exclusion to express its purpose the Texas legislature plainly intended that coverage be mandated only when the primary coverage of a policy is for health and accident coverage. Here the primary coverage is for the Plan's catastrophic losses." *Id.* at 1355.

The court also based its decision upon the Texas statutory definition of a group policy of accident and sickness insurance. Tex. Ins. Code Art. 3.51-6(1)(a) defines group accident and health insurance:

> "... to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:
>
> (1) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer ..."

The court held that a stop-loss policy does not fall within this definition of a group policy. "Read literally, the stop-loss policy purchased by the Plan is not an 'individual' or 'group' policy since it does not benefit individuals, but the Plan itself." 897 F.2d at 1355. Since the court of appeals' affirmance of the district court's decision was based solely upon state law, it never had to reach the ERISA preemption issues.

> "... [B]ecause we conclude that Article 3.70-2(E) does not apply to stop-loss insurance purchased by an employee benefit plan to insure that plan against catastrophic loss, we do not reach the ERISA preemption issues as to stop-loss insurance coverage."

Id. at 1352. The district court of Maine has also held that stop-loss insurance is not group insurance. In *Cuttle v. Federal Employees Metal Trades Council*, 623 F.Supp. 1154 (D. Me. 1985), the court had to determine whether a stop-loss policy fell within a state statutory definition of "group insurance" which is similar to the definition of "group accident and health insurance" in Tex. Ins. Code Art. 3.51-6(1)(a). In *Cuttle*, the plan was self-insured and had a stop-loss policy which reimbursed the plan for amounts paid by the plan in excess of $20,000. *Id.* at 1156. A Maine statute required group health insurance policies to include a provision permitting a terminating participant to convert his group coverage to an individual policy. The court held that the stop-loss policy was not a group insurance policy.

> "Neither can the statute be applied to the plan because it carries the stop-loss insurance. That policy is not a group health insurance policy within the meaning of the applicable statutes. 24-A M.R.S.A. §§2804-2806. All of those statutes specify that a group policy must be established to insure employees for the benefit of persons other than the union or trustee or employer which has obtained the group policy. The stop-loss policy insures the issuer of the plan for the benefit of the fund or plan."

Id. at 1157. Consequently, the court held that the conversion statute would not apply to the plan.

This Court has repeatedly held that it will not review a court of appeals' interpretation of a state statute. "Moreover, this Court must necessarily depend upon the district courts and courts of appeals for initial determinations of questions of state law; indeed, our practice of deference to such determinations should generally render unnecessary review of their decisions in this respect." *Cort v. Ash*, 422 U.S. 66, 72, 95 S.Ct. 2080, 2085, 45 L.Ed.2d 26 (1975). ". . . [T]his Court has accepted the interpretation of state law in which the District Court and the Court of Appeals have concurred even if an examination of the state-law issue without such

guidance might have justified a different conclusion." *Bishop v. Wood,* 426 U.S. 341, 346, 96 S.Ct. 2074, 2078, 48 L.Ed.2d 648 (1976). "The federal judges who deal regularly with questions of state law in their respective districts and circuits are in a better position than we to determine how local courts would dispose of comparable issues." *Butner v. United States,* 440 U.S. 48, 58, 99 S.Ct. 914, 919, 59 L.Ed.2d 136 (1979). "Normally, however we defer to the construction of a state statute given it by the lower federal courts." *Brockett v. Spokane Arcades, Inc.,* 472 U.S. 490, 499, 105 S.Ct. 2794, 2799, 86 L.Ed.2d 394 (1985).

The exception to the U.S. Supreme Court's deference to a court of appeals' interpretation of a state law is the situation in which the Court determines that the court of appeals is clearly wrong or erroneous in its interpretation. See *Bishop v. Wood,* 426 U.S. 341, n. 10 at 346, 96 S.Ct. 2074, n. 10 at 2078; *Brockett v. Spokane Arcades, Inc.,* 472 U.S. 490, n. 9 at 500, 105 S.Ct. 2794, n. 9 at 2800; and cases cited therein.

In the case at bench, Petitioners have not cited any regulation, interpretation or case which disputes the interpretation of Tex. Ins. Code Art. 3.70-2(E), Tex. Ins. Code Art. 3.70-1, or Tex. Ins. Code Art. 3.51-6(1)(a) by the Court of Appeals for the Fifth Circuit. In fact, Petitioners do not state anywhere in their Petition that they disagree with the court of appeals' interpretation of the Texas statutes. Since the court of appeals based its decision solely upon Texas statutes (rather than federal law), which the Petitioners do not dispute, this Court should not review the court of appeals' decision.

II. THERE IS NO CONFLICT AMONG THE CIRCUITS REGARDING WHETHER THE PURCHASE OF STOP-LOSS INSURANCE CONVERTS A SELF-INSURED PLAN INTO AN INSURED PLAN.

Petitioners imply that there is a conflict between the Court of Appeals for the Sixth Circuit and the Court of Appeals for the Ninth Circuit because of the decisions in *Michigan United Food & Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059, 106 S.Ct. 801, 88 L.Ed.2d 777 (1986), and *Moore v. Provident Life & Acc. Ins. Co.*, 786 F.2d 922 (9th Cir. 1986). *See* Petition for Writ of Certiorari at 5. Petitioners do *not* allege that the Fifth Circuit decision in *Brown* is in conflict with another circuit's decision regarding stop-loss insurance. A review of the facts in *Baerwaldt* and *Moore* reveals that the situations are very different in these cases and, therefore, they are not in conflict.

In *Baerwaldt*, plaintiffs were contesting whether a Michigan mandatory benefits law applied to their employee welfare benefit plan. Under that statute,

> " '[e]ach insurer offering health insurance policies in this state shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all contracts for, group and individual hospital, medical, surgical expense-incurred health insurances [sic] policies other than limited classification policies.' "

767 F.2d, n.1 at 310. The plans had purchased group insurance policies from Occidental Life Insurance Company. The plans would pay benefits up to a certain amount and, after that amount was reached, Occidental would pay *directly* to the participants any additional benefits under the applicable policies. The court held that the mandated benefits law fell within ERISA's savings clause. However, the plans were not exempt under the deemer clause because the Occidental

insurance policies paid benefits directly to the participants and the statute was intended to affect any insurer who offers health insurance policies in Michigan.

> "According to the Complaint's description of the plans, the plans include an arrangement whereby the plans pay premiums to Occidental to insure that Occidental will pay all benefits in excess of the claims liability limit under the group policies. As long as the plans purchase insurance from 'an insurer offering health insurance policies in' Michigan, the policies must include the substance abuse coverage specified by Act 429."

767 F.2d at 313.

In *Moore v. Provident Life & Acc. Ins. Co.*, a former employee brought suit to recover benefits under his former employer's self-funded employee benefit plan and for punitive damages for alleged violations of ERISA and California insurance law. In contrast to *Baerwaldt*, the employee benefit plan was covered by a stop-loss policy issued by Provident which reimbursed the plan when claims paid by the plan exceeded a specified aggregate amount during any policy year. 786 F.2d at 927. The court held that the plan fell "... within the 'deemer' clause as an uninsured plan, and [that] an excess coverage or a 'stop-loss' policy which protects the trust or other employee benefit plan from catastrophic loss does not change this result." In *Bone v. Association Management Services, Inc.*, 632 F.Supp. 493 (S.D. Miss. 1986), the court drew a distinction between the facts in *Baerwaldt* and *Moore:*

> "Due to the fact that insurance policy in question insures the Plan itself, and not individual participants, Plaintiffs' reliance on *Michigan United Food and Commercial Workers Unions v. Baerwaldt*, 767 F.2d 308 (6th Cir. 1985), is misplaced. Under the provisions of the partially insured plan at issue in *Michigan United Food*, the plan paid all health and welfare benefits up to an agreed amount and after that liability limit was reached,

> the insurer was liable to the individual participants for payment of additional benefits."

Bone, 632 F.Supp. at 495.

Petitioners had previously stated that there was also a conflict with the Sixth Circuit's decision in *Northern Group Services v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987), *cert. denied*, 486 U.S. 1017, 108 S.Ct. 1754, 100 L.Ed.2d 216 (1988), which involved a Michigan state insurance statute requiring auto liability carriers to provide reduced premium rates, deductibles and exclusions if the insured is covered by any health or accident plan. In exchange, the health or accident plan would be the primary insurance carrier for medical expenses arising out of a car accident and the auto insurer would be the secondary insurance carrier. The court refused to exempt any employee welfare benefit plan under ERISA from compliance with the coordination of benefits provision of the statute because of the potential injury to the state scheme.

> "Exemption of [this] plan and other self-insurers from the Michigan rule . . . would disrupt the State's ability to administer a uniform scheme of 'other insurance' or 'coordination of benefits' law. Not only would exemption frustrate the goal of cost containment, it would also create unpredictability and possibly undermine the financial stability of no-fault insurers."

Id. at 93.

However, two subsequent decisions by the Court of Appeals for the Sixth Circuit have modified the *Northern Group* decision. First, in *Liberty Mutual Ins. v. Iron Workers Health Fund*, 879 F.2d 1384 (6th Cir. 1989), the Iron Workers self-insured health plan excluded coverage for expenses incurred as a result of a car accident. Liberty Mutual sued the plan for reimbursement of medical expenses it paid on behalf of a union member who was injured in a car accident. The union member also was a participant in the Iron Workers health plan. The court held that Liberty Mutual was not

entitled to reimbursement because the Michigan statute only regulates the order of payment, primary or secondary. The statute does not regulate the contents of a plan.

> "The *Northern Group Services* court was not interpreting a statute which requires ERISA plans to provide coverage for automobile accidents even where the plan's unambiguous language excludes such coverage. Section 3109 . . . did not regulate the content of welfare benefits provided by ERISA plans, but merely required plans which provide automobile accident coverage to assume primary liability when such coverage is also provided by a no-fault carrier."

Id. at 1387-88. The *Liberty Mutual* decision substantially limited the impact of the original *Northern Group* decision. Employee welfare benefit plans are not required to include a state mandated benefit for expenses arising out of a car accident. Instead, the statute only determines who will be the primary carrier if the accident and health plan provides coverage for car accidents. The *Northern Group* decision was eroded even further by the Sixth Circuit in *Northern Group Services, Inc. v. State Farm Mutual Auto Ins. Co.*, 898 F.2d 1125 (6th Cir. 1990) (*"Northern Group II"*). The court of appeals there stated that "[f]or purposes of deciding the federal preemption question, and that question only, we merely assumed, without deciding, that the coordination rules of §3109a applied to both insured and uninsured ERISA plans." *Id.* at 1126. The court admitted that it did not decide in its original *Northern Group* decision whether the Michigan statute actually applies to a self-insured plan.

> "We ruled only on the federal claim of preemption, the federal issue then before us, and did not attempt to rule on any pendent state claim requiring an explication of state law. We did not consider or rule, for example, on the question whether uninsured ERISA plans constitute 'health and accident coverage' and thus whether §3109a — as a matter of state law — applied to self-insured plans."

Id. Therefore, according to the decision in *Northern Group II*, the Sixth Circuit has not yet reached the issue decided by the Fifth Circuit in *Brown*, namely, whether a self-insured plan covered by a stop-loss policy constitutes "health and accident coverage."

As discussed previously, Petitioners have not alleged in their Petition that there is a conflict between the Fifth Circuit's decision in *Brown* and any other decision from another circuit regarding the effect of stop-loss insurance on self-insured plans. The only cases cited by Petitioners are from the Sixth Circuit and the Ninth Circuit. However, as shown above, the facts and holdings involved in each decision reveal that the cases are so dissimilar that they cannot be considered in conflict with each other.

CONCLUSION

The Petition for Writ of Certiorari should be denied. The Court of Appeals for the Fifth Circuit based its decision upon Texas statutes. Petitioners have not raised any question regarding an error in the Fifth Circuit's interpretation of the state statutes. Further, the Petitioners have not cited any conflict among the circuits regarding stop-loss insurance which involves the decision in *Brown,* and they have conceded before the court of appeals that Tex. Ins. Code Art. 3.70-2(E) would not apply to the Plan itself. Finally, Petitioners' questions regarding ERISA's preemption of extra-contractual causes of action do not even involve the Fifth Circuit's decision in *Brown.* The court of appeals never reached the extra-contractual preemption issue because it determined that none of the Respondents were liable to Petitioners for Plan benefits.

For all of the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

JAMES J. MCCONN
Counsel of Record

NAOMI S. OSTFELD
SUSAN C. STEVENSON
HAYS, MCCONN, PRICE & PICKERING
400 Citicorp Center
1200 Smith Street
Houston, Texas 77002
(713) 654-1111

Counsel for Respondent,
North American Life and
Casualty Company